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Assimilative Processes in a Client with Borderline Personality Disorder: Tracking Internal Multiplicity over the First Ten Sessions of Therapy

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Abstract

The assimilation of problematic experiences as operationalization of internal multiplicity has been studied as change processes in psychotherapies of different client populations. However, there is little research investigating the assimilation processes with a particular focus on clients with borderline personality disorder (BPD), as they engage in treatment. Internal multiplicity describes the presence, within the person, of different centers of experience, called inner "voices". These may result from unresolved traumatic experiences associated with BPD. The current study is a theory-building case study, which aims at understanding the evolution of internal multiplicity in a short-term treatment over 10 sessions for a client with BPD, aiming at engagement in long-term treatment. The case, Louise, presents with a high potential of internal conflicts, showing four antagonistic problematic voices. The intensive assimilation analysis of these voices, with regard to the dominant voice, suggests that their assimilative change tends to pass from chaotic multi-voice cacophony to a structuring two-voice dialogue (i.e., a mutual elaboration of the conflicts). Our results underline that internal dialogue between previously opposed voices may be a productive way for clients with BPD to evolve in therapy and use their internal multiplicity as a resource. Narrative details and illustrations are presented to document Louise's change processes over her process of engagement in therapy.

Key-Words: Assimilation Model; Borderline Personality Disorder; Psychotherapeutic Change; Internal Multiplicity

ASSIMILATIVE PROCESSES IN A CLIENT WITH BORDERLINE PERSONALITY DISORDER: TRACKING INTERNAL MULTIPLICITY OVER THE FIRST TEN SESSIONS OF THERAPY

Introduction

Unresolved traumatic experiences influence identity integration in clients presenting with borderline personality disorder (BPD; Ball & Links, 2009; Fossati, Maddedu, & Maffei, 1999; Golier, Yehuda, Bierer et al., 2003; Paris, 1998; Schmahl, & Bremner, 2006; Zanarini, 2000). Such experiences may affect a number of psychological processes, such as the quality of representations, relationship patterns, capacities of mentalizing, interpersonal schemas, affect regulation and attachment (Beck, 1996; Flanagan, 2014; Fonagy, Gergely, Jurist, & Target, 2002; Fonagy, Leigh, Steekem, Steele, Kennedy, Mattoon et al., 1996). These psychological processes may affect, in turn, mental health. They may interfere with efficient treatment, compromise balanced affective experience and stable interpersonal relationships.

Traces of early traumatic experiences may affect identity formation and produce a number of internally disconnected experiences. If this is the case, rapidly shifting identity-states may be the consequences of external triggers, a clinical problem described in relation with BPD (Gunderson & Sabo, 1993; Herman, Perry & van der Kolk, 1989; Lobbestael, Vreeswijk, & Arntz, 2007; Zanarini & Frankenburg 1997). Executive functioning and control (i.e., working memory, problem solving capacities) was shown to be associated with such externally fluctuating identity states and with poor quality of collaboration in therapy (Levy, Beeney, Wasserman, & Clarkin, 2010). Alternatively, even though early traumatic experiences were related to the BPD-diagnosis, there are other explanations of the development of this disorder, for example in relationship with attention and mood disorders (Fossati, Novella, Donati, Donini, & Maffei, 2002).

Internal multiplicity is one possible conceptualization of the effects of unresolved traumatic experiences associated with BPD. Internal multiplicity denotes the presence, within the person, of several partially or completely contradictory parts, opinions, experiences, which may be described by using the metaphor of inner "voices" (Hermans & Dimaggio, 2004; Lysaker & Lysaker, 2005). Despite this conceptualization and some initial empirical research (e.g, Humphreys, Rubin, Knudson, & Stiles, 2005; Osatuke, Humphreys, Glick, Graff-Reed, Mack & Stiles, 2005; Osatuke & Stiles, 2006), to date, there is little research investigating the *change* processes of internal multiplicity and of identity over the course of the very first treatment sessions. Johnson, Smailes, Cohen, Brown & Bernstein (2000) have pointed out that clients with PD presenting with severe episodes of neglect, abuse or other interpersonal trauma have specific internal experiences which potentially interfere with optimal relationships and effective therapeutic processes, which is particularly relevant in the very beginning of treatment with PD. In order to elucidate these processes, Fernandez-Alvarez, Clarkin, Carmen del Salgueiro and Critchfield (2006) suggest that an analysis of the assimilation of such problematic experiences (Stiles, 2001) may be useful and represents an important research avenue in order to describe and understand client processes, irrespective of the type of the specific therapeutic intervention. Such an analysis of the client's narrative is consistent with the overall aims of psychotherapy integration focusing on detailed understanding of *client* processes in therapy (Wolfe, 2008) – rather than therapist techniques – , and is therefore very much in order.

The foundations of the concept of internal multiplicity are twofold. Firstly, internal multiplicity is an implication of the narrative perspective on the self, as summarized by Angus and McLeod (2004): individuals tell different versions of the same story to themselves and to others, depending on the individual's representations of the audience's interests, expectations and the characteristics of the situation. The "same" story becomes a different one every time it

is re-constructed by the narrator (Hermans & Dimaggio, 2004). Understood in this way, the self is not just loosely composed by some cognitions, motivations and affects, but the self becomes a potentially coherent organization and a dynamic construction, with a number of inner links between parts of the self.

Secondly, internal multiplicity can be understood as implication of earlier theories of utterance and discourse (Bakhtin, 1981). The contents of the individual's utterings are shaped by the anticipated response of the other (i.e., to whom the content is addressed). The other person in this conception usually involves a number of invisibly present persons to whom the person actually speaks, and rarely only the persons who happen to be in the room. In essence, the construction of new meaning as part of a narrative involves the invisible other and imposes on the speech analysis the idea of the dialogue (for methodological implications, see Leiman, 2004). Whereas in traditional discourse analysis – analogue to dialogue philosophy (Buber, 1957) – dialogues are mostly of interpersonal nature - between I and Thou -, the concept of internal multiplicity, as used here, focuses on *internal dialogues* unfolding within the self.

So, internal multiplicity stems from (a) the notion of multiple narratives in the self (different "voices"), and, (b) the idea of dialogue between these internal voices. Such internal dialogues can therefore be understood as means towards integration of problematic or traumatic experiences into a more coherent self (Stiles, 2001; Stiles, Osatuke, Glick & Mackay, 2004; Whelton & Greenberg, 2004). Such a conception is highly promising for the understanding of change processes in treatment for clients with BPD, it is so central that several therapy models have conceptualized their interventions from an internal multiplicity perspective. For example, schema therapy uses the mode concept (Beck, 1996) to explain the different parts of the internal experience, such as the modes of the detached protector, punitive parent, vulnerable and angry child (Flanagan, 2010; 2014; Lobbestael, Vreeswijk, &

Arntz, 2007; Young, Klosko, & Weishaar, 2003). With such a conceptualisation, different aspects of the client's narrative may be classified and explained by generic functions. The formulation of the latter may also help the clients to recognize their internal multiplicity. Several therapy forms use Gestalt-type two-chair dialogues to resolve internal multiplicity (Greenberg, 2002; Kellogg, 2004; Kramer & Pascual-Leone, 2013; Pos & Greenberg, 2012; Stone & Stone, 1989; Arntz & Van Genderen, 2010). In this context, internal multiplicity is defined according to a set of internally constructed and dynamically changing "voices" which may be enacted in two-chair dialogues. Such enactment, in particular in emotion-focused therapy, follows a number of specific transformational step towards resolution of the underlying emotional state. Given this importance of internal multiplicity for clinical purposes, a rigorous and intervention-independent observation of these change processes over the first sessions of therapy is central. An integrative way of operationalizing such client change processes in internal multiplicity is the assimilation model.

The Assimilation Model: observing change in the client

The assimilation model (Stiles, Meshot, Anderson, & Sloan, 1992; Stiles, 1999; 2002) is an integrative research model that provides a means to understanding change processes in clients undergoing any psychotherapy; it does not imply direct clinical intervention. Traces of previously problematic or traumatic experiences – represented as active ("agentic") internal "voices" by the model (Osatuke, & Stiles, 2006; Stiles, 1999) – are transformed over the course of therapy, by being assimilated into integrated and unproblematic aspects of the self. These may then function as resources for the client. In total, eight levels, or developmental stages, of assimilation of problematic voices have been identified (see Table 1). The model has developed based on a number of carefully performed intensive theory-building case studies (Stiles, 2005; 2007). The aim of these studies is the development of a coherent model of change in clients, based on the assumption of progressive integration of conflictual voices.

Authors tend to agree that the internal multiplicity in clients with Personality Disorders has distinctive features (e.g., Elliott, Watson, Goldman & Greenberg, 2004; Semerari, Carcione, Dimaggio, Nicolo, & Procacci, 2004; Young et al., 2003). From the assimilation model perspective, Osatuke and Stiles (2006; see also Osatuke, 2005 and Osatuke, Gray, Glick, Stiles and Barkham, 2004) understand the therapeutic process related to a client with BPD as a *shift* of internal dominance from one particular part of the self to another. Unlike in clients without BPD where therapeutic progress is conceived as a lessening of the impact of the internal dominance (i.e., of a particular internal part; a voice or a "community of voices"), towards a more open and integrated self, in clients with BPD, the self tends to be composed by different sub-communities of voices – aggregations of interlinked traces of experiences – which are disconnected from each other as their perspectives are incompatible. Their integration into the self is therefore a complex process. In this case, a sub-community is called dominant if it is the client's actual center of experience (i.e., a specific way of acting, thinking and presenting oneself to the world). In this context, the unassimilated voice is problematic to the dominant (sub-) community in the sense that it questions its validity and provokes tendencies of avoidance of that unassimilated voice by the dominant community (Osatuke & Stiles, 2006).

For example, a client who tends to present as collaborative may, in order to maintain his/her identity (i.e., the dominant community of voices), may deny, dissociate or push away experiences of aggression and jealousy (i.e., unassimilated or "problematic" voices). Such an example a self-presentation as particularly collaborative was described as "detached protector" problematic part within a complex self in clients with BPD (Flanagan, 2014). Also, split-off aggression was described to be particularly relevant in clients with borderline features (Kernberg, 1984). Verbal aspects of such an unassimilated (i.e., in this example the aggressive) voice may be integrated into the coherent self, whereas non-verbal and behavioral

parts of this unassimilated voice are actually "problematic" to the community. This distinction may results in behavioral aggression without much awareness or representation, as present in some forms of acting out typical of BPD (Fonagy et al., 2002). It was also shown that such unassimilated parts present with a different vocal qualities, observable on audiotaped interaction (Osatuke et al., 2004; Osatuke, Humphreys, et al., 2005).

In addition, it is not only the dominant community of voices – the coherent self, in our example the self-presentation as collaborative – which has the power to define a voice as "problematic"; individual voices may also do so. For example, the shaming voice (e.g., "You are no good and should hide") might not be fully integrated into the dominant community, so it is therefore "problematic" itself and, at the same time, the shaming voice defines the aggressive voice as unacceptable or "problematic". Given this complexity, internal multiplicity needs to be investigated carefully in these individuals. In addition to traditional assimilation analysis (see Method section and Osatuke & Stiles, 2000) in which the problematic and the dominant voices are to be identified, for clients with BPD, two aspects need to be taken into account: (a) the definition for whom (in the community of inner voices) the problematic voice is particularly problematic (i.e., "which other part of the self has defined this specific experience as problematic?") and (b) the therapy-long tracking of assimilation processes (i.e., "how exactly do the multiple experiences evolve?"). This process may imply multiple tracks of conflicting voices progressively integrating one with each other or on the contrary, separating, as the process of change evolves and broadens, and tracking of depth of processing and breadth of the specific.

So far, such analysis is rare in the literature, despite several calls for qualitative case study research. Such research should enable to understand early progression of assimilation of problematic experiences in clients with BPD (Osatuke & Stiles, 2006; Fernandez-Alvarez, Clarkin et al., 2006). A focus on early progression is crucial in order to understand initial

psychological processes involved in the client's engagement in therapy over the initial sessions. Therapy engagement is particularly central with clients presenting with BPD (Gunderson & Links, 2006).

The purpose of the current theory-building case study is to use the assimilation model to describe and understand the initial evolution of internal multiplicity in a short-term treatment over 10 sessions for a client with BPD.

Method

Design and context

The present study is a theory-building case study (Stiles, 2005; 2007). As such, we aim at producing observations from a clinical case presenting with BPD, which have the potential of informing and "infusing" the assimilation model, and in particular the tracking of the problematic experiences over the initial sessions of therapy. We aim at understanding the dynamics of engagement in therapy from an idiographic client-centred perspective. Therefore, we will only present narrative details and illustrations related to our theory-driven research question related to the client processes and will not elaborate on other details of the case (e.g., personality features, case formulation, traumatic history).

The case stems from a randomized controlled trial (RCT) which aimed at the study of the additive effects of Plan Analysis and the motive-oriented therapeutic relationship (Caspar, 2007) on process and outcome in a ten-session outpatient psychiatric assessment and treatment for BPD. In this RCT, all clients received a 10 sessions variant of General Psychiatric Management (GPM; Gunderson & Links, 2008), and half of the sample, using randomized allocation to either group, received additionally the Plan Analysis case formulation and the motive-oriented therapeutic relationship (Caspar, 2007). In a nutshell and knowing that this is not the focus of the present paper, we can summarize that Plan Analysis

is a qualitative method focusing on the conceptualization of the client's behavior-underlying acceptable motives, which are supposed to be instrumentally linked with manifest in-session behaviors and experience. Such a conceptualization involves as a consequence, client-tailored therapist interventions focusing on the client's acceptable motives, instead of on the manifest client's problematic behaviors and Plans themselves. The 10-session version of GPM, as basis of both conditions involved in the cited RCT, involves good psychiatric management of borderline states, from a psychodynamic-attachment based perspective (Gunderson & Links, 2006). The main results of the RCT are reported by Kramer, Kolly, Berthoud, Keller, Preisig, Caspar et al. (2014) and present differential effects favoring the motive-oriented therapeutic relationship. For the interested reader, a clinical example of the specific therapist intervention is elaborated by Kramer, Berthoud, Keller and Caspar (2014). A prototypical Plan Analysis for BPD is available in the literature, as well (Berthoud, Kramer, de Roten, Despland, & Caspar, 2013). The detailed Plan Analysis case formulation for the present case may be obtained from the authors upon request.

It is central to note that the therapist was unaware of the general internal multiplicity literature in BPD and the interventions did not intend to change assimilative processes.

The client and the therapeutic process

The client was chosen among the completers of the RCT mentioned, based on three criteria: (1) the client underwent 10 or more sessions, maximising the observed length of the therapy process; (2) all sessions were available on audio- or video-material and the quality of the recordings were sufficiently good, (3) the initial case formulation was based on the Plan Analysis which enabled to assess, from a perspective independent from the assimilation-analysis, the degree of internal multiplicity. In this context, hypothesized internal multiplicity was defined as (a) presence of at least 2 internal conflicts between Plans and motives; (b)

presence of at least 6 Plans or behaviors related to internally divergent self-presentations. Out of the 31 client completers in the Plan Analysis/motive-oriented therapeutic relationship condition (Kramer, Kolly et al., 2014), *n* = 13 clients met criteria 1 and had 10 or more sessions. Out of the 13 clients, 8 had all 10 sessions available in sufficient quality enabling detailed process-analysis (criterion 2). Finally, when analyzing the 8 remaining Plan Analyses, there was one female client who presented with increased markers of internal multiplicity (*n* = 3 specific internal conflicts and 10 low-level Plans or behaviors that relate to divergent self-presentations, as defined in the context of the Plan Analysis approach). Therefore, this client was chosen for assimilation analysis.

Louise, 27 years old, consulted for a psychological exhaustion related to a marital conflict. Married for 5 years, Louise is in the process of separation from her husband Ben. The couple has a 4 year old son. Louise had trained as secretary and had a part-time job until recently. At the time of consultation, she was unemployed and just about to get re-employed for a new position. She presents with borderline personality disorder according to DSM-IV (6 criteria out of 9, as assessed using the SCID-II, First, Spitzer, Williams & Gibbons, 2004, involving, among others, intense fear of abandonment, anger and impulsivity problems and an instable pattern of interpersonal relationships) and bulimia (as assessed using the MINI, Lecrubier, Sheehan, Weiller, Amorim, Bonora, Harnett Sheehan et al., 1997). Her symptom severity was overall mild to moderate at intake (see Table 2), which is consistent across all self-report measures assessing problems (Outcome Questionnaire-45 (OQ-45; Lambert, Morton, Hatfield, Harmon, Hamilton, Reid Shimokowa, Christoperson & Burlingame, 2004), Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988) and Borderline Symptom List (BSL; Bohus, Kleindienst, Limberger, Stieglitz, Domsalla, Chapman, Steil, Philipsen & Wolf, 2009)). Outcome data were assessed after

sessions 4, 7 and 10 (discharge), as was the therapeutic alliance (using the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989)) from the client and therapist perspectives.

The client received once-weekly outpatient therapy for a total of 10 sessions, which included 2 structured assessment sessions using the SCID and MINI. After this period, Louise was referred to long-term outpatient psychotherapy. Outcome data showed a stability of the general problems over the 10 sessions, but an impressive increase in the domain of self-reported interpersonal problems at session 4, for example related to expressed hostility and social retreat behaviors. This momentary peak was also found for the specific borderline symptoms (i.e., with increase on interpersonal mistrust and internal tension and affective arousal) which were the only symptoms which decreased from intake to discharge. The temporary increase in interpersonal and borderline symptoms observed after session 4 may be related to a current external stressor in Louise's life: she needed to confront with her husband in the context of her divorce. On average, Louise's symptom scores were below the cohort's averages and median rates of change (Kramer, Kolly et al., 2014). Louise did not get any medication to treat her problems and her GAF-score (Global Assessment of Functioning) was 70 at intake. The therapeutic alliance was steadily increasing over the course of the 10 sessions of treatment, both from the client and the therapist perspective, and their mean scores averaged above the cohort's means (Kramer, Kolly et al., 2014).. The client gave written consent of this material to be used for research. For the presentation of the case material, we modified minor details of the case, in order to fully protect the client’s privacy.

Process Instrument

Assimilation of Problematic Experiences (Stiles, 2001). The assimilation process was assessed using the Assimilation of Problematic Experiences Scale (APES). This scale is based on a developmental conception of assimilation, as outlined above, and encompasses 8 levels

of progressive integration of problematic or traumatic experiences in the Self. Table 1 describes the stages one by one. The rating was done using a manual (Stiles & Osatuke, 2000).

Procedure

After therapy was completed and the trial terminated, we selected the case to be analyzed for internal multiplicity, according to the three criteria outlined. Then, we identified all voices, using a two-step procedure according to Osatuke, Glick, Stiles, Greenberg, Shapiro and Barkham (2005, p. 99). First, we identified voices based on the transcript of the intake session which was done independently by two raters. Then, the two raters met and discussed in a collaborative fashion until reaching a first provisional consensus concerning the client's voices. Then, a second round of independent work concerned the establishment of a so-called catalogue of topics – in essence, this is a chronological summary of the engaged themes discussed in each session - for all remaining 9 sessions. This point is based on the procedures developed by Stiles and Osatuke (2000). This work of establishing the catalogue of topics was done by the first rater, then handed to the second for the preparation of the further consensus. Based on this summarized material and taking the first consensus of voices as a start, both raters worked again independently to determine the final formulation of the client's voices, taking now into account all the summaries of the 10 sessions. After this phase, both raters met for a subsequent consensus meeting where a final decision about the voices involved in the client's self was reached. This step enabled to have a final version of the voice formulation which was used for the next step. All 10 sessions were then rated by the first author using the APES-scale (Stiles & Osatuke, 2000), based on the transcripts and the video- and audio-recordings. The actual APES-rating involved three steps: (1) the event-selection of the moments to be rated were based on the recommendations by Stiles and Osatuke (2000); (2) then the APES-ratings involved the selection of the voice speaking, either the dominant voice

(no rating by definition, as no divergence from nor dialogue with the assimilated community of voices observed) or one of the problematic voices identified; finally, the APES-levels, i.e., actual level of assimilation of the voice with regard to the dominant voice or the dominant community of voices, are rated for each event and each voice.

Two randomly chosen sessions of the therapy process served as reliability checks: sessions 1 and 7 (20% reliability sample); these sessions were rated independently by two raters.

Results

Preliminary analyses

The reliabilities using two independent raters were established on three indices separately: (1) event selection, (2) voice selection, and (3) level of assimilation. For the event selection, the two raters reached 91% of agreement (32 events in total) for session 1 and 60% of agreement (27 events in total) for session 7. On average, 76% of agreement on event selection was considered acceptable. For the voice selection, the two raters reached 71% of agreement (28 events in total) for session 1 and 65% of agreement (17 events in total) for session 7. On average, 68% of agreement on voice selection was considered borderline, but acceptable. In order to demonstrate reliability of the actual APES-ratings, we performed Intra-Class correlation coefficients for the two sessions that were rated by the independent raters, taking all APES-ratings independently from the actual voice rated. For session 1, we found ICC (1, 2) = .74 and for session 7, we found ICC (1, 2) = .66 (both session together ICC (1, 2) = .70). All three indices of reliability levels being overall acceptable, we concluded that the APES-ratings were reliably performed in this study.

Presentation of the problematic voices

The dominant voice in Louise's self-presentation was termed "Louise the wise and responsible person." This voice involved Louise's adapted self, who collaboratively enters therapy and recognizes that therapy may help. This dominant voice is "unproblematic" from Louise's subjective perspective, but is central in understanding her internal dialogues and what the "problematic" voices have to say. From an objective perspective, this dominant voice (or community of voices) may cause problems to Louise in that it may create distance from the inner experience or from healthy attachment. By definition, however, this voice served only as anchor to the ratings of the other voices, as no internal dialogue is possible within one single dominant voice. Three problematic voices in Louise's self-presentation were identified.

(1) "Louise who is angry and wants to stand up for herself." (*Angry*). This voice is problematic in the eyes of the dominant community (voice) and voice number 2 (Enmeshed); conflict between these voices may create guilt. For example, Louise's expression of wanting to be independent and separated from her husband Ben illustrates the angry voice and may be inhibited, at times, by the enmeshed voice of wanting to stay connected with him.

(2) "Louise who is enmeshed or in dependency with the other persons."(*Enmeshed*). The enmeshed voice is problematic in the eyes of voice number 3 (Mad) and 4 (Victim). For example, Louise's expressed wish to stay with her son, her identity as a caring mother and wanting to be there for him, as representative of the enmeshed voice, may be inhibited by the uncontrollable outbursts of anger or "madness", as she puts it (mad voice).

(3) "Louise the mad person who loses control over herself." (*Mad*). The mad voice is problematic in the eyes of the dominant community and voices number 1 (Angry) and 2 (Enmeshed). For example, this voice expresses itself mostly in the form of the impulsivity problems occurring outside of the therapy room.

(4) "Louise the victim". (*Victim*). Finally, the victim voice is problematic in the eyes of the dominant community and voices 1 (Angry) and 2 (Enmeshed). For example, in the communication with her husband Ben, Louise reported being regularly “bullied” by him, or even psychologically abused. Note that the voices emerged from Louise’s narrative and may only apply to this particular context.

Tracking of the evolution of the problematic voices and their progressive assimilation

The occurrence of each voice per session was computed using percentages (i.e., relative occurrence with regard to the total number of sequences analyzed). The total number of sequences analyzed averaged on 11.40 (*SD* = 5.43) per session. Preliminary analyses yielded that sessions 5 and 6 had a very low number of sequences analyzed (2 and 4, respectively) and therefore, the percentages found per voice occurrence were less meaningful. This was related to the specific content of these sessions: these two sessions were straight-forward diagnostic assessment sessions using the MINI and the SCID-II, as integral part of the psychiatric treatment process (see above). Because of possible difficulty of interpreting data based on very little observation points from sessions 5 and 6, these sessions were excluded from further analyses.

When analyzing the eight sessions in terms of occurrence for each voice, it appeared that the victim voice was highly present at the very beginning of the therapy (sessions 1 and 2) and completely disappeared in the last four sessions (see Figure 1). Instead, two other voices essentially appear, which were almost absent from the very first sessions of therapy: the angry and enmeshed voices. Finally, the mad voice did not reach higher percentages than 20% (maximum attained at session 7) and finally disappeared at the end of the therapy process. What is most striking in Figure 1, however, is the sawtoothed up-and-down of the angry and enmeshed voices, sharing together consistently 80 to 100% of the sequences

analyzed in the last four sessions. In what follows, we will first give examples of excerpts related to the victim voice (session 1), then illustrate the sawtoothed up-and-down of the angry and the enmeshed voices, respectively (sessions 7 through 10).

The following excerpt from session 1 occurred only 10 minutes into the very initial therapeutic contact, but illustrates very clearly the problematic voice of victim speaking.

> "Now, all is coming out! And everybody starts to understand what's really going on! Why our couple did not work. Why I became this person I am actually not! It's because...my husband Ben is… someone who manipulates and knows how to talk well, even a swindler! That's it, yes! And now, we all understand things better. Everybody understands things better now." (S1, al. 182, rated as victim APES-level 2).

Five minutes later into the same session, Louise states:

> "This is what really happened, I tell you! My husband is a heavy smoker, even more than just cigarettes... And one day, he, he dared to blow his smoke into my face telling me: 'don't you dare stop smoking!' And I said, 'This is uncomfortable for me. I want you to respect this. And I want you to empty the ashtray yourself. It's not my job to do this for you all the time.' And he says to me: 'no!' and gets up and laughs. This is driving me crazy!" (S1, al. 228, victim voice APES-level 2).

The enmeshed and angry voices both emerge after mid-treatment (session 7 out of 10) and showed a saw-toothed pattern of presence. The enmeshed voice may be seen in the following excerpt (at minute 15 into session 7):

> Client: (speaking about her son) "He speaks to somebody in his plays, in his imagination, he has a friend who listens to him, he has his own family in his room. Even if he is walking around, he says he is giving his hand to his friend, these are

small things, but I tell myself, it's my fault, and at the same time, I tell myself, no, it's not all bad, it's even good, he is imaginative. But I had never thought that my son would have an imaginative friend, this is it."

Therapist: "so you say it's your fault..."

Client: "Yes, I'm telling myself that this is the consequence of the separation and he is looking for a different life... And I tell myself, if we still had our little family life, this would not happen, I don't know. I wonder about this, but I also know that it is as it is." (S7, enmeshed voice, APES-level 2).

Only 40 seconds later, the client states:

"I am overwhelmed, especially in the evening, I am unable to watch TV and get something out of it. I loved to watch films on TV, or also shows and everything, but I am unable to get something out of it. I am too busy. I have to think so much, for the next day, for the entire week, about what I am going to do for my son. This is it." (S7, al. 159, enmeshed voice APES-level 0)

The angry voice, where the client starts to stand up for herself emerges at mid-therapy as well. For example, at session 8, the following excerpt:

Client: "I don't want to be fake with my son."

Therapist: "You have already told me this before and you said that you want to be more honest with the other persons around you...."

Client: "Exactly, I want to stop veiling my face. Before, when something did not please me, I did not say anything, I only put it out... months later...or I did not say anything at all. But now, when I have something to say, I say it with a strong voice,

> and gently too. It needs to come out and afterwards, I always feel better." (S8, al. 482, angry voice, APES-level 3).

In session 9, the angry voice makes progress in progressively assimilating with the dominant community of voices, by stating:

> "The baby I had in my arms, when my son was born, is not the same person anymore today. And also myself I have changed, as has my ex-husband. Today, I feel guilty, because I was not a good enough mother. I was not properly supported by my ex-husband, this deceives me, this makes me angry. It is a milestone in the life of a woman to become a mother. My ex-husband did not have enough force at the time, he was not capable of supporting me and us. Maybe he was too young for the task." (S9, al. 310, angry voice APES-level 4).

This last excerpt is a fine example for a beginning dialogue between the angry voice, the enmeshed voice and the dominant voice (or community of voices, related to Louise's presentation of being wise and responsible). The problematic experience of being angry at her ex-husband Ben appears to be a resource for the dominant voice, enabling the regulation of distance with him and producing new meaning related to the current and the past situation. The dialogue between the angry, enmeshed and dominant voices produces here guilt which does have an impact on the angry voice being softer.

When looking at the mean assimilation levels per session for the two main problematic voices (i.e., angry and enmeshed; see Figure 2), it appears that there is steady increase in assimilation for both voices observed after session 7 of the 10-session therapy. Whereas the voice's mean-levels per session varied between 1.5 and 2.5 on the 7-point APES-scale during sessions 1 until 7, for the last 3 sessions, their mean-levels were between 3 and 4. On the APES-scale, it was demonstrated that this level is particularly productive, as it involves the

introduction of a meaning bridge, linking different voices into a constructive dialogue between each other (Brinegar, Salvi, Stiles & Greenberg, 2006) which prepares the progressive integration into the community of voices to form a coherent self.

Discussion

The present intensive case study analysis investigated internal multiplicity and its evolution over the first ten sessions of therapy for a case presenting with borderline personality disorder (BPD), by taking the vantage point of the assimilation model. The case chosen presents with a high potential of internal conflicts, as illustrated with the different antagonistic problematic voices. As such, this study extends earlier studies on this client population, in particular it helps to understand the dynamics of engagement in therapy, described as being a central for patients with PD (Fernandez-Alvarez et al., 2006; Gunderson & Links, 2008). This in-depth understanding of client engagement in therapy goes beyond specific therapy interventions.

From a multi-voice cacophony to a two-voice dialogue

This short treatment in 10 sessions aiming at client engagement in long-term psychotherapy can be broken down into two successive phases: a first phase characterized by a multi-voice cacophony (session 1 through 4) and a second phase with a more structured two-voice dialogue (sessions 7 through 10). This has clear implications from an assimilative viewpoint.

The first phase tends to present with low degrees of assimilation of any voice into the dominant community. Here, problematic voices, consistent with Osatuke and Stiles' (2006) observations, define each other as problematic and do not enter mutual dialogue. In fact, it can be postulated that they avoid each other, thus preventing further assimilation. We would call it a multi-voice cacophony, without much order and chaotic pattern of changes and turn-taking

between the different parts of the self. This lack of order in the internal multiplicity might be paralleled with what other authors have called the stable instability in the experience of clients with BPD (Grinkler, Werble, & Drye, 1968; Gunderson & Sabo, 1993; Schmideberg, 1959; Osatuke & Stiles, 2006), or, alternatively, explain in process terms what Kernberg (1984) described as identity diffusion as a diagnostic feature of BPD. It may also demonstrate constant switching between or "flip-flopping" of distinct modes of presentation, in particular the momentary presence of detached protector and more vulnerable and angry stances (Flanagan, 2014; Loebbestael et al., 2007). The voices observed in this phase cover a great array of contents, from the stance of accusing others of not being respectful with the self, over the accusation of oneself of being out of control, to the implicit search for comfort within intimate relationships (and lack thereof), along with the self-presentation of Louise the wise and responsible person. It is noticeable that several voices focus on the external world. This focus on the external world by the voices involved is also reflected by the lower levels of assimilation of the problematic experiences. In fact, level 1 on the APES may involve, in addition to unclear negative affect, projective elements and an initially external focus of the voice (Osatuke & Stiles, 2000). Interestingly, level 1 of the APES was found to be the level of integration for all the voices of the cacophony; it is almost as if these voices block each other to further progress. They are doing this without actually speaking to each other, without entering an actual dialogue, but they probably do this on an implicit level (and on a low level of assimilation). As such, the chaotic multi-voice cacophony may be one characteristic of so-called borderline processes (Eckert & Biermann-Ratjen, 1998; Elliott, Watson, Goldman & Greenberg, 2004), as underlying psychological processes which may be involved in more than one psychiatric disorder - not just BPD - but may be present in several psychiatric disorders in case of acute stress or trauma.

The second phase is qualitatively different from the first. Out of this great number of voices, there are two emerging – and mutually conflicting – voices, which share close to a 100% of the sequences analyzed: the enmeshed and angry voices. These voices are present from the beginning of therapy, however, they were not utilized by the self as potential resources, but they were split-off, ignored or remained unconsidered. The second part of Louise's therapy gives to these voices the specific space they need to take center stage in the internal dialogue and elaborate their mutual conflict, together with the dominant voice. It is noticeable that these two voices focus mainly on the inner experience, tend to speak from their core to say what they have to say. They mostly convey fundamentally unacceptable experiences (in the eyes of the dominant voice of wise and responsible). This is reflected, again, by the assimilation levels of the voices in this second phase of the treatment: in this phase, the voices tend to be more integrated, completely absorbed in the dialogue with each other and thus, co-constructing a new self. It is almost as if these problematic voices are pushing each other, by the sawtoothed ups and downs depicted in Figure 1, in an emulative way, towards better mutual assimilation and integration. An even clearer argument speaking in favour of greater progressive integration of problematic experiences into the self is the depicted in Figure 2: the central two voices of this phase (angry and enmeshed) reached the highest assimilation towards the end of the 10-session therapy. Therefore, what was stated before on the level of the definition of what is a problematic voice may find its counterpart for the evolution of the voices: their degree of assimilation is not only defined by the dominant community, but the two voices in dialogue may mutually define and support, through their constructive dialogue, their mutual assimilative progression and integration. The emergence of guilt as a complex emotion related to the internal dialogue between the angry, enmeshed and the responsible (dominant) voices is an interesting observation in the case of Louise. Such a process may therefore be called a dialogue between at least two problematic voices, which

may be a productive way for clients with borderline processes, as explained above, to evolve in therapy and use their internal multiplicity as a resource. An alternative explanation of the increased quality of the dialogue may be that the therapeutic sessions have contributed to quiet all the voices, in the sense of an enhanced regulation process bringing down the level of intensity. With the lessening of the disruptive quality, the voices were able to acknowledge each other and use each other as resources.

The results found in the present intensive assimilation analysis are consistent with, but also go beyond existing clinical models focusing on internal multiplicity of BPD. For example, schema therapy, cited earlier, has developed a number of prototypical modes to be observed in clients with BPD (Lobbestael et al., 2007; Young et al., 2003). The angry and enmeshed voices found here might be paralleled with specific mode presentations according to this model, like the angry and vulnerable child. However, our rigorous process-observation has fostered the emergence of ideographically-formulated nuances and shades of the specific experiences (e.g., illustrating the angry voice standing up for herself: “I want to stop veiling my face(…) when I have something to say, I say it with a strong voice”, S8, al. 482) which were unanticipated by any categorical approach to internal multiplicity. Therefore, single case studies are most central in generating idiographic content which has the potential of transforming the underlying generic explanatory model.

Whereas a more structured two-voice dialogue emerged, as predicted by the assimilation theory and earlier studies (Osatuke et al., 2004; 2006), the present case did not present with a shift in internal dominance, as observed by Osatuke et al., nor did we find a full integration of the problematic voices (Osatuke & Stiles, 2006). These divergences from the theory are not surprising, given the short time frame of the intervention, focusing on client engagement in therapy, and the absence of a specific focus on internal multiplicity by the therapist.

Internal multiplicity, therapeutic alliance and symptom change

The case of Louise may help to tie together the understanding of assimilation processes, as a form of tracking of internal multiplicity, with quantitative measures of the therapeutic alliance and symptom change. It was reported that Louise had below-cohort-average symptom levels, except for the increase in interpersonal and borderline symptoms observed after session 4. Whereas it is plausible that this temporary increase is related to the external stress in Louise's current life situation (i.e., the divorce), we may offer here a more comprehensive understanding in terms of the evolution of the voices. In fact, Louise's central theme of this therapy was the assimilation of various experiences related with her current intimate relationship. The divorce situation was highly stressful for her and produced increased levels of specific problems. On a psychological level, the divorce may have stimulated the internal voice of anger, hitherto unassimilated, to take progressively centre stage (see excerpt from session 9) and dialogued with the dominant voice of being wise and responsible. The client stands up for herself and asserts her wishes; therefore, this type of anger experience is consistent with what Pascual-Leone and Paivio (2013; see also Greenberg, 2002) have called the primary adaptive assertive anger. In this experience, the client is fully connected with and endorses his/her needs and holds ground by speaking in favour of them, usually when a threat of intrusion is perceived. At the same time as a correlate of the divorce, Louise is about to lose her core intimate relationship which stimulates the emergence of the enmeshed voice. Both voices emerge around session 4 and take center stage in the therapy process thereafter. We may speculate that the emergence of these two voices, including their mutual dialogue, might help the client to process and absorb the increased levels of interpersonal and borderline symptoms observed after session 4 and, eventually, contribute to recovery from borderline symptoms after discharge. In particular, the observed decrease of interpersonal distrust and hostility (between session 4 and 10) may be understood

as a correlate of a more integrated and asserted sense of self at the end of 10 sessions. It remains an open question to what extent the emergence of guilt, as exemplified by the excerpt from session 9, hinders or facilitates this assimilation process. The steady increase of the therapeutic alliance, both from the client and the therapist perspectives, may be a necessary condition for the client to progressively integrate these problematic aspects into a new construction of the self.

Therapists mindful of these multi-vocal dynamics of engagement in therapy related to BPD may use the different voices in a more productive fashion, from the first session on. For example, it may be useful to foster the emergence of two distinctive (and conflictual) voices in the client. Such early structuring of the internal dialogues helps the client's assimilation of problematic, or traumatic, experiences and may increase engagement and collaboration later in therapy. It has been noted that client's engagement in inner dialogues implying two voices is particularly fruitful for change (Elliott & Greenberg, 1997). Internal multiplicity involving the presence of two voices over a number of sessions, rather than a greater number (a "cacophony"), is more accessible to clinical understanding and treatment, in particular using variants of two-chair dialogues for clients with BPD (Elliott et al., 2004; Kellogg, 2004; Kramer & Pascual-Leone, 2013; Pos & Greenberg, 2012).

Limitations and perspectives

The present intensive theory-building case study used the assimilation model to examine internal multiplicity and its evolution over a short treatment for a client with borderline personality disorder. Whereas a great number of methodological controls are made in the research procedure in order to enhance the quality of the study, we need to acknowledge the singularity of the observations, where $N = 1$. According to Stiles (2007), conclusions from such a design may not be generalizable in a traditional fashion – directly to

other clients –, but may infuse and inform the theoretical model of change used in the present study, the assimilation model of progressive change elucidating here the dynamics of engagement in therapy. By doing so, we did not describe the traumatic origins of Louise's voices, nor which needs were not met in her development.

Ten sessions of therapy is certainly not enough for the healing of long-standing problems related with BPD. Despite this major limitation of the present case study, it is remarkable that in the end of this short-term treatment, albeit remaining somewhat at the surface of Louise's functioning, a structured two-voice dialogue emerged. It would therefore be meaningful to explore longer therapy processes with regard to assimilative change, in particular therapy processes which explicitly foster productive work with internal multiplicity, such as emotion-focused therapy (Pos & Greenberg, 2012), compassion focused therapy (Gilbert, 2010) or schema therapy (Arntz & Van Genderen, 2010; Young et al., 2003).

Despite the limitations, the processes observed in the present study may inform the understanding of assimilative change of borderline processes, which tends to pass from chaotic multi-voice cacophony to a structuring two-voice dialogue, in order to achieve constructive therapy engagement. Ultimately, such a two-step meta-evolution may be important for the understanding of therapeutic change involved in clients presenting with BPD. In these cases, internal multiplicity may both hinder change and serve as a resource for progression. Further research should examine the exact temporal patterns of these two functions of internal multiplicity to borderline processes: it should be investigated when and under what circumstances internal multiplicity favours and hinders the therapeutic progression.

References

Angus, L., & McLeod, J. (2004). Self-multiplicity and narrative expression in psychotherapy. In H. J. M. Hermans, & G. Dimaggio (Eds.), *The dialogical Self in Psychotherapy*. (pp. 77- 90). New York: Brunner-Routledge.

Arntz, A., & van Genderen, H. (2010). *Schematherapie bei Borderline-Persönlichkeitsstörung*. Basel: Beltz.

Bakhtin, M. M. (1981). Discourse in the novel. In M. Holquist (ed.), *The Dialogical Imagination: Four Essays by M. M. Bakhtin* (pp. 258-422). Austin, TX: University of Texas Press.

Ball, J. S., & Links, P. S. (2009). Borderline personality disorder and childhood trauma: Evidence for a causal relationship. *Current Psychiatry Reports, 11*, 63-68.

Beck, A. T., (1996). Beyond belief: A theory of modes, personality, and psychopathology. In P. M. Salkovskis (Ed.), Frontiers of Cognitive Therapy (pp. 1-25). New York, NY: Guilford Press.

Berthoud, L., Kramer, U., de Roten, Y., Despland, J.-N., & Caspar, F. (2013). Using Plan Analysis in psychotherapeutic case formulatioin of Borderline Personality Disorder. *Clinical Psychology and Psychotherapy, 20,* 1-9.

Bohus, M., Kleindienst, N., Limberger, M. F., Stieglitz, R. D., Domsalla, M., Chapman, A. L., Steil, R., Philipsen, A., & Wolf, M. (2009). The short version of the borderline symptom list (BSL-23): development and initial data on psychometric properties. *Psychopathology, 42,* 32-39.

Brinegar, M. G., Salvi, L. M., Stiles, W. B., & Greenberg, L. S. (2006). Building a Meaning Bridge: Therapeutic Progress from Problem Formulation to Understanding. *Journal of Counseling Psychology*, *53*(2), 165-180.

Buber, M. (1957). *I and Thou*. New York: Scribners.

Caspar F (2007). Plan Analysis. In T. D. Eells (Ed.), *Handbook of Psychotherapy Case Formulations. Second Edition* (pp. 221-289). New York: Guilford Press.

Eckert, J., & Bierman-Ratjen, E.-M. (1998). The treatment of borderline personality disorder. In L. S. Greenberg, J. W. Watson, & G. Lietaer (Eds.), *Handbook of Experiential Psychotherapy* (pp. 349-367). New York: Guilford Press.

Elliott, R., & Greenberg, L. S. (1997). Multiple voices in process-experiential therapy: Dialogues between aspects of the self. *Journal of Psychotherapy Integration, 7*, 225-239.

Elliott, R., Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2004). *Learning Emotion-Focused Therapy. The process-experiential approach to change*. Washington, D. C.: American Psychological Association.

Fernandez-Alvarez, H., Clarkin, J. F., Carmen del Salgueiro, M., & Critchfield, K. L. (2006). Participant factors in treating Personality Disorders. In L. G. Castonguay, & L. E. Beutler (Eds.), *Principles of Therapeutic Change that Work* (pp. 203-218). New York: Oxford University Press.

First, M. B., Spitzer, R. L., Williams, J. B. W., & Gibbons, M. (2004). *Structured Clinical Interview for DSM-IV*. New York: Biometrics Research Dept.

Flanagan, C. M. (2010). The case for needs in psychotherapy. *Journal of Psychotherapy Integration, 20*, 1-36.

Flanagan, C. M. (2014). Unmet needs and maladaptive modes: A new way to approach longer-term problems. *Journal of Psychotherapy Integration, 24*, 208-222.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization and the development of the self.* New York: Other Press.

Fonagy, P., Leigh, T., Steekem, M., Steele, H., Kennedy, R., Mattoon, G., Target, M., & Gerber, A. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology, 64,* 22-31.

Fossati, A., Madeddu, F., & Maffei, C. (1999). Borderline personality disorder and childhood sexual abuse: a meta-analytic study. *Journal of Personality Disorder, 13*, 268-280.

Fossati, A., Novella, L., Donati, D., Donini, M., & Maffei, C. (2002). History of childhood attention deficit/hyperactivity disorder symptoms and borderline personality disorder. *Comprehensive Psychiatry, 43*(5), 369-377.

Gilbert, P. (2010). *Compassion focused therapy*. New York, NY: Routledge.

Golier, J. A., Yehuda, R., Bierer, L. M. et al. (2003). The relationship of borderline personality disorder to posttraumatic stress disorder and traumatic events. *American Journal of Psychiatry, 160*, 2018-2024.

Greenberg, L. S. (2002). Integrating an emotion-focused approach to treatment into psychotherapy integration. *Journal of Psychotherapy Integration, 12,* 154-189.

Grinkler, R., Werble, B., & Drye, R. (1968). *The borderline syndrome: a behavioral study of ego-functions*. New York: Basic Books.

Gunderson, J. G., & Links, P. S. (2008). *Borderline Personality Disorder: A Clinical Guide.* Washington, D. C.: American Psychiatric Publishing Inc.

Gunderson, J. G., & Sabo, A. (1993). The phenomenological and conceptual interface between childhood trauma and borderline personality disorder: Conceptual and clinical implications. *Journal of Personality Disorders, 11*, 50-70.

Herman, J. L., Perry, J. C., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry, 146*, 490-495.

Hermans, H. J. M., & Dimaggio, G. (Eds.)(2004). *The dialogical Self in Psychotherapy*. New York: Brunner-Routledge.

Johnson, J. G., Smailes, E. M., Cohen, P., Brown, J., & Bernstein, D. P. (2000). Associations between four types of childhood neglect and personality disorder symptoms during adolescence and early adulthood: Findings of a community-based longitudinal study. *Journal of Personality Disorders, 14*(2), 171-187.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureno, G., & Villasenor, VS. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56,* 885-892.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223-233.

Humphreys, C., Rubin, J. S., Knudson, R. M., & Stiles, W. B. (2005). The assimiliation of anger in a case of dissociative identity disorder. *Counseling Psychology Quarterly, 18* (2), 121-132.

Kellogg, S. H. (2004). Dialogical encounters: Contemporary perspectives on “chair work” in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 41*, 310-320.

Kernberg, O. F. (1984). *Severe Personality Disorders. Psychotherapeutic strategies.* New Haven: Yale University Presss.

Kramer, U., Berthoud, L., Keller, S., & Caspar, F. (2014). Motive-oriented psychotherapeutic relationship facing a patient presenting with Narcissistic Personality Disorder: A case study. *Journal of Contemporary Psychotherapy, 44,* 71-82 . Doi: 10.1007/s10879-013-9249-5

Kramer, U., Kolly, S., Berthoud, L., Keller, S., Preisig, M., Caspar, F., Berger, T., de Roten Y., Marquet, P., & Despland, J.-N. (2014). Effects of motive-oriented therapeutic relationship in a ten-session general psychiatric treatment of borderline personality disorder: a randomized controlled trial. *Psychotherapy and Psychosomatics, 83,* 176-186. DOI: 10.1159/000358528.

Kramer, U., & Pascual-Leone, A. (2014). La chaise vide en psychothérapie : origines et développements. *Pratiques Psychologiques, 19,* 41-53.

Lambert, M. J., Morton, J. J., Hatfield, D., Harmon, C., Hamilton, S., Reid, R. C., Shimokowa, K., Christoperson, C., & Burlingame, G.M. (2004). *Administration and Scoring Manual for the Outcome Questionnaire-45.* Orem, UT: American Professional Credentialing Services.

Lecrubier, Y., Sheehan, D. V., Weiller, E., Amorim, P., Bonora, I., Harnett Sheehan, K., Janavs, J., & Dunbar, G. C. (1997). The Mini International Neuropsychiatric Interview (MINI). A short diagnostic structured interview: reliability and validity according to the CIDI. *European Psychiatry, 12,* 224-231.

Leiman, M. (2004). Dialogical sequence analysis. In H. J. M. Hermans & G. Dimaggio (eds.), *The dialogical self in psychotherapy* (pp. 255-270). New York: Brunner-Routledge.

Levy, K. N., Beeney, J. E., Wasserman, R. H., & Clarkin, J. F. (2010). Conflict begets conflict: Executive control, mental state vacillations, and the therapeutic alliance in treatment of borderline personality disorder. *Psychotherapy Research, 20*(4), 413-422.

Lobbestael, J., Vreeswijk, M. F., & Arntz, A. (2007). Shedding light on schema modes: A clarification of the mode concept and its current research status. *Netherlands Journal of Psychology, 63*, 76-85.

Lysaker, J., & Lysaker, P. (2005). Being interrupted: The self and schizophrenia. *Journal of Speculative Philosophy, 19*(1), 1-21.

Osatuke, K. (2005). *Hearing voices: Verbal and vocal cues of internal multiplicity*. Ph.D. Dissertation. Oxford, OH: Miami University.

Osatuke, K., Glick, M. J., Stiles, W. B., Greenberg, L. S., Shapiro, D. A., & Barkham, M. (2005). Temporal patterns of improvement in client-centered therapy and cognitive-behaviour therapy. *Counselling Psychology Quarterly, 18*(2), 95-108.

Osatuke, K., Gray, M. A., Glick, M. J., Stiles, W. B., & Barkham, M. (2004). Hearing voices: methodological issues in measuring internal multiplicity. In H. J. M. Hermans, & G. Dimaggio (Eds.), *The dialogical Self in Psychotherapy*. (pp. 237-254). New York: Brunner-Routledge.

Osatuke, K., Humphreys, C. L., Glick, M. J., Graff-Reed, R. L., McKenzie Mack, L., & Stiles, W. B. (2005). Vocal manifestations of internal multiplicity: Mary's voices. *Psychology and Psychotherapy: Theory, Research and Practice, 78*, 21-44.

Osatuke, K., & Stiles, W. B. (2006). Problematic internal voices in clients with Borderline Features: An Elaboration of the Assimilation Model. *Journal of Constructivist Psychology, 19*, 287-319.

Paris, J. (1998). Does childhood trauma cause personality disorders in adults? *Canadian Journal of Psychiatry, 43,* 148-153.

Pascual-Leone, A., Paivio, S. C. (2013). Emotion-focused therapy for anger in complex trauma. In E. Fernandez (Ed.) *Treatments for anger in specific populations. Theory, Application and Outcome* (pp. 33-51). New York: Oxford University Press.

Pos, A. E., & Greenberg, L. S. (2012). Organizing awareness and increasing emotion regulation: Revising chair work in Emotion-Focused Therapy for Borderline Personality Disorder. *Journal of Personality Disorders, 26*(1), 84-107.

Schmahl, C., & Bremner, J. D. (2006). Neuroimaging in borderline personality disorder. *Journal of Psychiatry Research, 40,* 419-427.

Schmideberg, M. (1959). The borderline patient. In S. Arieti (Ed.), *American Handbook of Psychiatry, Vol. 1* (pp. 398-416): New York: Basic Books.

Semerari, A., Carcione, A., Dimaggio, G., Nicolo, G., & Procacci, M. (2004). A dialogical approach to patients with personality disorders. In H. J. M. Hermans, & G. Dimaggio (Eds.), *The dialogical Self in Psychotherapy*. (pp. 220-234). New York: Brunner-Routledge.

Stiles, W. B. (1999). Signs and voices in psychotherapy. *Psychotherapy Research, 9,* 1-21.

Stiles, W. B. (2001). Assimilation of problematic experiences. *Psychotherapy, 38,* 462-465.

Stiles, W. B. (2005). Case studies. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 57-64). Washington, DC: American Psychological Association.

Stiles, W. B. (2007). Theory-building case studies of counselling and psychotherapy. *Counselling and Psychotherapy Research, 7*(2), 122-127.

Stiles, W. B., Meshot, C. M., Anderson, T. M., & Sloan, W. W. Jr. (1992). Assimilation of problematic experiences: The case of John Jones. *Psychotherapy Research, 2*, 81-101.

Stiles, W. B., & Osatuke, K. (2000). Assimilation analysis. Unpublished manuscript. Miami, OH: Department of Psychology, Miami University.

Stiles, W. B., Osatuke, K., Glick, M. J., & Mackay, H. C. (2004). Encounters between internal voices generate emotion: an elaboration of the assimilation model. In H. J. M. Hermans, & G. Dimaggio (Eds.), *The dialogical Self in Psychotherapy*. (pp. 91- 107). New York: Brunner-Routledge.

Stone, A., & Stone, S. (1989). *Embracing ourselves: The voice dialogue manual*. Novato CA: Bataraj Publishing.

Whelton, W. J., & Greenberg, L. S. (2004). From discord to dialogue: internal voices and the reorganization of the self in process-experiential therapy. In H. J. M. Hermans, & G. Dimaggio (Eds.), *The dialogical Self in Psychotherapy*. (pp. 108 - 123). New York: Brunner-Routledge.

Wolfe, B. E. (2008). Toward a unified conceptual framework of psychotherapy. *Journal of Psychotherapy Integration, 18*, 292-300.

Young, J. E., Klosko, J., & Weishaar, M. (2003). *Schema therapy: A practitioner's guide.* New York, NY: Guilford Press.

Zanarini, M. C. (2000). Childhood experiences associated with the development of borderline personality disorder. *Psychiatric Clinic in Northern America, 23*, 89-101.

Zanarini, M., & Frankenburg, F. (1997). Pathways to the development of borderline personality disorder. *Journal of Personality Disorders, 11*, 93-104.

Table 1

Assimilation of Problematic Experiences Scale (APES) (Honos-Webb et al., 1999, p. 1443)

0	Warded off. Client is unaware of the problem. Affect may be minimal, reflecting successful avoidance.
1	Unwanted thoughts. Client prefers not to think about the experience; topics are raised by therapist or external circumstances. Affect involves unfocused negative feelings; their connection with the content may be unclear.
2	Vague awareness/emergence. Client is aware of a problematic experience but cannot formulate the problem clearly. Affect includes acute psychological pain or panic associated with the problematic experience.
3	Problem statement/ clarification. Content includes a clear statement of a problem – something that could be or is being worked on. Affect is negative but manageable, not panicky.
4	Understanding/insight. The problematic experience is formulated and understood in some way. Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.
5	Application/working through. The understanding is used to work on a problem. Affective tone is positive, optimistic.
6	Problem solution. Client achieves a successful solution for a specific problem. Affect is positive, satisfied.

7	Mastery. Client automatically generalizes solutions. Affect is positive or neutral (i.e., this is no longer something to get excited about).

Note. The APES stages are understood as representing an underlying continuum of assimilation.

Table 2

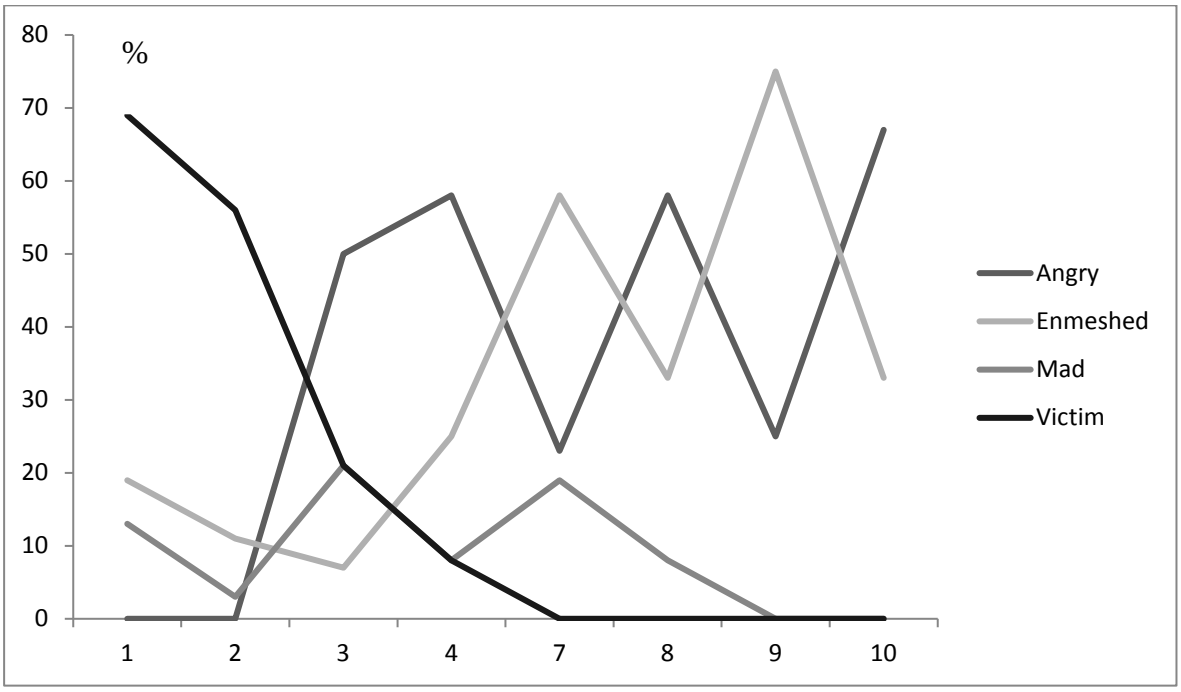
Psychopathological and therapeutic characteristics of the case over time (4 assessment points)

	Intake	Session 4	Session 7	Discharge
OQ-45	56	50	60	60
IIP	0.83	2.33	0.88	0.88
BSL	1.17	2.30	0.43	0.43
WAI				
Client	49	49	69	71
Therapist	57	55	65	65

Note. OQ-45: Outcome Questionnaire - 45.2; IIP: Inventory of Interpersonal Problems; BSL: Borderline Symptom List; WAI: Working Alliance Inventory.

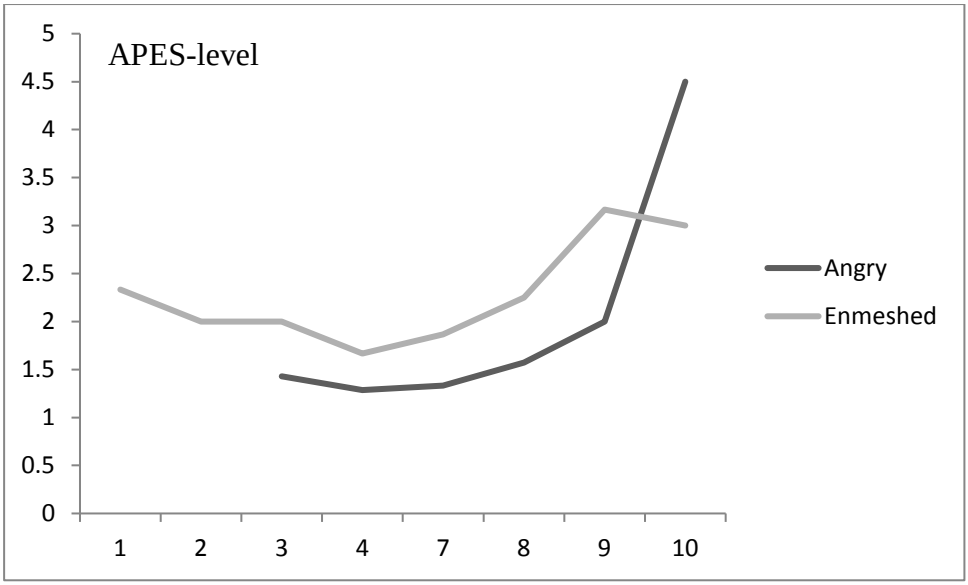
Figure 1

Session-by-session tracking all four problematic voices (victim, mad, enmeshed and angry) in Louise's narrative over therapy



Note. Percentage of occurrence for each voice per session. Sessions 5 and 6 excluded, because of very few observations for each session (DSM-IV SCID diagnostic interviews).

Figure 2: Progressive levels of assimilation of the angry and enmeshed voices in Louise's narrative over ten sessions of therapy



Note. APES (Assimilation of Problematic Experiences Scale)-level for Angry and Enmeshed-voices for each session. Sessions 5 and 6 excluded, because of very few observations (DSM-IV SCID structured diagnostic interviews).